MHSOAC
Mental Health Services Oversight and Accountability Commission
Meeting Minutes
July 28, 2011

AMENDED

California Institute for Mental Health
Sequoia Room
2125 19th Street, 2nd Floor
Sacramento, California
866-817-6550; Code 3190377

1. Call to Order

Chair Poaster called the meeting to order at 9:06 a.m.

2. Roll Call

Commissioners in attendance: Dr. Larry Poaster, Chair; Richard Van Horn, Vice Chair; Sheriff William Brown, Dr. Victor Carrion, Dr. Ralph Nelson, Jr., Andrew Poat, and Tina Wooton. Dr. David Pating joined the meeting after the roll call.

Not in attendance: Senator Lou Correa, Assemblymember Mary Hayashi, Patrick Henning, Jr., Howard Kahn, and Eduardo Vega.

Seven members were present and a quorum was established.

Chair Poaster shared that Commissioner Kahn was resigning from his Mental Health Services Oversight and Accountability Commission (MHSOAC) seat effective August 26, 2011. His term had expired and he graciously served on the Commission until his position as the Chief Executive Officer of L.A. Care Health Plan made this unfeasible.

Chair Poaster expressed the hope that Commissioner Kahn could briefly attend the September 22, 2011 Commission meeting so his contributions as a Commissioner could be officially recognized.

Commissioner Kahn holds the seat on the MHSOAC designated for a representative of a health care services plan or insurer. Recruitment to fill this seat will begin in the Governor's Office.

Chair Poaster further stated that Commissioner Henning is in the process of accepting a new position that may make him ineligible for the Commission seat that he currently holds as a labor representative. The Commission will be monitoring this situation.

3. Adoption of May 26 and June 23, 2011 MHSOAC Meeting Minutes

Motion: *Upon motion by Commissioner Van Horn, seconded by Commissioner Poat, the Commission voted unanimously to adopt the May 26 and June 23, 2011 Meeting Minutes.*

MHSOAC Calendar, Revised July 2011

Chair Poaster stated that a revised MHSOAC Calendar was available.

MHSOAC Dashboard, June and July 2011

Chair Poaster pointed out that the MHSOAC Dashboard had been made current.

Commissioner Poat thanked Executive Director Gauger and MHSOAC staff for their work on revising the Dashboard format.

4. <u>Mental Health Funding and Policy Committee</u>

State Budget Update

Mental Health Funding and Policy Committee Chair Poat welcomed Mr. Don Kingdon, Deputy Director of the California Mental Health Directors Association (CMHDA). Mr. Kingdon gave a presentation on the Fiscal Year (FY) 2011/12 State Budget, summarized below.

- Assembly Bill (AB) 100, an important part of the FY 2011/12 budget process, happened early. Its major component was the use of Mental Health Services Act (MHSA) funds to backfill State General Fund obligations.
- Assembly Bill (AB) 3632 was repealed, which resulted in the transfer of responsibility for providing mental health and residential services to special education students from the counties to the schools.
    - $319 million in funding to education will support this transfer in FY 2011/12.
- As part of AB 100, counties are receiving transitional MHSA redirected funds of $98.6 million.
- There was a proposed consolidation of responsibilities to the Department of Health Care Services (DHCS) for Medi-Cal programs.
- The Legislature and the Administration were successful in passing a Public Safety realignment which will have a significant impact on health and human services and mental health.
- Critical elements of AB 100 are as follows:
    - CMHDA made recommendations on a distribution approach for Managed Care, Early Periodic Screening, Detection, and Treatment (EPSDT), and Special Education that were approved by the Department of Finance and the State Controller's Office.

  - Administrative efficiency is built into AB 100. Most of this is related to funds scheduled for distribution in FY 2011/12.

- From the CMHDA perspective, the county mental health role is to ensure that EPSDT beneficiaries continue to be served.
- The Legislature approved and the Governor signed a transition of specialty mental health programs from being administered by the Department of Mental Health (DMH) to DHCS. This will occur during FY 2011/12. A number of stakeholder meetings have convened to begin this process and the goal of DHCS is to conduct the transition in an open and transparent way. DHCS must submit their transition plan to the Legislature by October 1, 2011.
- There is a proposal to change the functions of DMH and the Department of Alcohol and Drug Programs (ADP). This is slated for FY 2012/13.
- The transition of the Medi-Cal program to DHCS has a short timeframe.
- Several programs have been realigned from the State to the counties. It is important to CMHDA that the Health and Human Services programs which have entitlement programs associated with them are not impacted by increased costs on the correctional side.
- There will be a community corrections partnership meeting convened in every county, led by the Chief Probation Officer.
- Adult Day Health Care will be eliminated effective September 1, 2011. This will have an impact on families in the communities and possibly on adult mental health.
- CMHDA will be closely following the potential shift of Healthy Families to Medi-Cal.
- People living in the community who are dependent on Supplemental Security Income (SSI) will see a huge drop in their income as SSI/State Supplementary Payment grants are cut.
- There will be an eight percent reduction in grants to the California Work Opportunities and Responsibility to Kids program.

Commissioner Poat asked Mr. Kingdon to explain how realignment works for counties and the impact of tax revenue being used to fund county mental health programs. Mr. Kingdon explained that the real impact on mental health programs will occur in FY 2012/13. AB 119 specifies a process for FY 2011/12, but only has intent language for FY 2012/13. The California State Association of Counties and its affiliates will develop and propose a process for FY 2012/13. It is important to note that starting in FY 2011/12, there will be no State General Fund money in the community mental health system and all funding will be tax-based. Tax revenue is counter-cyclical with funds decreasing as need increases and counties will need to learn how to manage this type of funding

source. It will be important to keep administrative requirements down as every dollar spent on administration/indirect costs is a dollar not spent on direct service.

Commissioner Poat remarked that the total State budget is about $90 billion and it is difficult to track where all of the money is going.

He added that it is interesting from the MHSOAC standpoint to see the continued interest in devolution of responsibility in programming to communities; we see this in mental health and corrections. He felt that this is a very constructive direction as there is tremendous capacity at the local level. The policy implication for the MHSOAC is determining the State role relative to assuring funding, assuring outcomes, and dealing with the differences between counties.

Commissioner Poat went on to say that this budget year is not yet over and there is a second round of budget cuts for which we are at risk if anticipated revenues are not achieved.

Commissioner Brown shared Commissioner Poat's belief in local responsibility for programs and felt that conceptually it is a good idea. However in some respects, particularly the corrections side, adequate resources are not in place. We should keep in mind that many of the counties do not have the necessary infrastructure or resources to affect the transfer.

Commissioner Poat noted that for this Commission there is much policy thinking that needs to happen in the next couple of years which should provide a rich opportunity for us to help define what the new service delivery models will be.

Recommendations on Prudent Reserve

Commissioner Poat gave a presentation on the revised Prudent Reserve Policy, summarized below. He noted that it was not urgent for the Commission to adopt the Prudent Reserve recommendations presented today and these recommendations can be taken back to the Mental Health Funding and Policy Committee for a second read. The Commission could adopt the Prudent Reserve recommendations in the fall.

- The purpose of Prudent Reserves is to address volatility associated with the MHSA funding source. Reserves are deposited through county plans and updates.
- In the past a Prudent Reserve policy with a 50 percent reserve for direct service programs was established for Community Services & Supports (CSS) and Prevention & Early Intervention (PEI) programs. No requirement was suggested for non-service programs.
- Counties were originally supposed to have these reserves in place by June 30, 2011. This requirement was suspended due to the current statewide economic conditions.

- AB 100 changed the Prudent Reserve requirements so that annual deposits are limited. The focus is on those programs that provide a service to mental health consumers.
- Also under AB 100, state plan review and approval was terminated.
- The counties rather than DMH will now have responsibility to decide how much should be in the Prudent Reserve funds.
- The vast majority of counties have established and funded the reserves, with five counties accessing the reserves to date as of July 18, 2011.
- Commissioner Poat highlighted the need for up-to-date information that is readily available to those who need it. There was originally some concern that the information used for this report was not up-to-date and difficult to gather. His hope was that as the Commission moves forward we will make sure that our Prudent Reserve policy, as being implemented by the counties, is one of the areas that we will have some informational support.
- Some policy implications came out of the Committee discussion.
    - There is not currently a meaningful track record by which to evaluate effectiveness of Prudent Reserve policy, because the current impact of revenues has not been fully transparent.
    - The Prudent Reserve policy properly emphasizes local control, and will require some adjustment of the MHSOAC's oversight roles.
- The Committee recommends that it develop strategies to provide oversight of Prudent Reserves within this new policy environment.
- The Committee also recommends that it provide a report to the Commission in the summer of 2014 with the next major assessment for this reserve program. By then, the current recession will hopefully be over and we will have learned more about how the counties have used the reserves to buffer the impact of program cuts.
- The Committee offered a proposed motion for direction from the MHSOAC, to develop Prudent Reserve oversight strategies consistent with AB 100 policy changes, and to provide a report to the Commission in the summer of 2014.
- Prudent Reserves are an important concept, and the State would be well-served to expand the policy of reserves beyond mental health and the MHSA. Setting aside money during higher revenue years and using it during lower revenue years would result in fewer service cuts.

Chair Poaster confirmed with Commissioner Poat that he did not wish to pursue a motion for this item today. Commissioner Poat stated that he wanted to hear public comment on this item and that he would take the Prudent Reserve policy recommendations back to the Committee, with the intent of presenting them for adoption at the September 2011 Commission meeting.

Commissioner Nelson questioned if the MHSOAC was going to investigate why data was missing/not available for certain counties. Commissioner Poat responded that he hoped to see a staff report in the future that would address this issue. At this stage our goal is to have a policy framework in the new mental health policy environment. Now that we have the framework, the next step is to analyze it and develop policy implications.

Commissioner Brown noted that some counties did not have any data and two of the counties did not have any reserve. He questioned if the Welfare and Institutions Code required counties to establish reserve and if the code provided guidelines on how the reserve is spent. Commissioner Poat responded that it appears the reserve is used to fund MHSA programs and those programs are established within a planning approval process. Funds should stay within that framework. Appropriate data is needed in order to review how the funds are spent and assure tax payers and stakeholders that the money is being used effectively.

Public Comment

- Mr. Donald Clark, client and family member, commented on the need to look at an even bigger picture of how to reinforce funding as we move to the future. He did not see any palpable bridges between MHSA funding and the federal block grant for community mental health. In addition, he felt that parents of children with mental impairments do not receive an equal response from the school system compared to parents of children with physical impairments. He also voiced concern that Senate Bill (SB) 511 (Family Empowerment Centers) deals with mental health yet we are not doing anything about it.
- Ms. Carmen Diaz, parent and family member, questioned regarding AB 3632, that from a parent's perspective who is going to keep an eye on children needing evaluation and services? Also, at the county level, is it not the Board of Supervisors who ultimately decides where funding goes, and if so, who will educate that group on the MHSA?
- Ms. Joy Torres voiced concern about MHSA funding being in county Prudent Reserves because the Boards of Supervisors will be making decisions on using these dollars rather than the mental health community.

5. <u>CalMHSA Semiannual Update</u>

Dr. Wayne Clark, California Mental Health Services Authority (CalMHSA) Board President, gave a presentation on "Current Status of PEI Statewide Projects." Below are highlights.

- Dr. Clark recognized several people for their work on the project, including Mr. Allan Rawlings, Mr. Ed Walker, Mr. John Chaquica, former MHSOAC staff member Ms. Ann Collentine and Ms. Stephanie Welch.

- In June of 2010, 17 of the 58 counties were members. In July 2011, the number had grown to 38 of the 58 counties. The plan is for 100 percent participation by December 2011.
- The implementation process started immediately after the CalMHSA Statewide PEI Implementation Work Plan was approved on January 27, 2011.
- Dr. Clark went through the timeline of Request for Proposals (RFP)s and Request for Application (RFA)s released for Suicide Prevention, Stigma and Discrimination Reduction, and Student Mental Health, including review panels and stakeholder involvement. Contracts will be executed in August 2011.
- Dr. Clark listed the approved programs and their providers for Suicide Prevention, Stigma & Discrimination Reduction, and Student Mental Health.
- Statewide evaluation timeframe is March 2011 through September 2011 for development of Contract Relationship Management (CRM) software; early August 2011 for Request for Qualifications (RFQ) release; early September 2011 for RFQ responses due; and late September 2011 for selection of the proposal for contract.
- Program implementation begins in September 2011.
- $135.5 million of program funds are assigned.
- The goals are:
    - Full county membership within the next six months.
    - Ensure that reversion is handled in a way that we can evaluate the programs after a three-four year period.
    - Look at CalMHSA for potential roles in other projects.

Questions and Discussion

Commissioner Pating inquired where CalMHSA hopes to transition after the successful run of the next three-four years. Dr. Clark replied that sustainability will be one of the key points. Reinvestment in some of the projects will be part of the next steps. The effort that CalMHSA can make collectively is greater than any individual effort.

Ms. Collentine, Program Director for CalMHSA, added that many of these programs are infrastructure-building and setting up systems, therefore continued funding will not be required for many of them.

Commissioner Poat felt that getting 89 percent of the population covered is a huge accomplishment and asked Dr. Clark if there were any assessments made regarding the 11 percent that are not yet in?

Dr. Clark responded that:

- Many of those counties are smaller ones with a long list of priorities to address.
- The project staff has worked with Alameda County (a large county) to join the Joint Powers Agreement (JPA).
- There has been a change in policy and a county no longer has to assign funds to the JPA in order to join, which will free up several of the counties.
- Mr. Allan Rawlings has been assigned as the diplomat to talk to San Benito, Mono, and Alameda Counties.

Chair Poaster commented that what has occurred up to now is quite impressive as to the nimbleness of CalMHSA to get things out. As it moves to the next phase, where CalMHSA begins to partner with other agencies and organizations, Chair Poaster hoped that they feel the same urgency in terms of getting things on the ground, so that it is visible to the general public.

Dr. Clark noted that on behalf of the State of California, CalMHSA had also submitted a Substance Abuse and Mental Health Service Administration grant to have California put a children's system of care plan in place by September 2012. This planning grant is for about $800,000 and 35 different agencies support it.

6. <u>Evaluation Committee</u>

Evaluation Committee Chair Van Horn stated that the MHSOAC has participated in the California Health Information Survey (CHIS), and has had several questions which are directly related to mental health issues in the last two surveys. The MHSOAC is using CHIS as a way of identifying needs and gaps in mental health services.

Dr. Sergio Aguilar-Gaxiola, Director of the Center for Reducing Health Disparities, University of California, Davis (UCD), gave a presentation on the first survey: "Assessing Adult Mental Health Needs in California Using the California Health Interview Survey (CHIS)." Following are highlights.

- This particular report focuses on adult mental health needs and is one report out of four. Two reports look at Medi-Cal data and another looks at county data.
- Serious Psychological Distress (SPD) is based on the Kessler 6 (K6) – a series of questions about feelings of distress.
- The CHIS 2007 found that out of 26,769,450 adults in California, there were 2,286,602 (8.3 percent) classified as having SPD. Of these, 2,224,400 had an impairment in at least one domain. These adults were classified as having a Mental Health Need.

- Impairment is measured in three levels: Severe, Moderate, and No Impairment. It can occur in four domains: performance at work, household chores, social life, and relationship with family and friends.
- The poorest segments of the population had higher levels of mental health needs.
- Those with public (non-Medicare) insurance and the uninsured had the highest levels of mental health need.
- Of race/ethnicity, American Indians had the highest mental health need.
- By place of birth, U.S.-born Latinos had the highest mental health need.
- Of languages spoken in the home for those with SPD, 64 percent spoke English only.
- Those with mental health needs tend to be associated with other health conditions: 30 percent are smokers and 29 percent are binge drinkers.
- Dr. Aguilar-Gaxiola anticipated that when we look at diabetes, hypertension, asthma, etc., there will be a very high co-occurrence with mental health needs.
- Mental health treatment was measured with three questions about frequency of doctor visits, frequency of mental health professional visits, and use of prescription medications.
- Of those with mental health need, about half (49.6 percent) reported that they received treatment while the other half (50.4 percent) reported that they did not.
- About one-third of those who received treatment were taking daily prescription medications.
- The findings show that:
    - SPD is in large part a function of economic position, for example, Latino immigrants and single parents with children.
    - When you control by age, gender, income, and education, the mental health needs are still highest in American Indian/Alaskan Natives, followed by Native Hawaiian/Pacific Islanders.
    - Looking at nativity status, when you control by age, gender, income, and education, U.S.-born Latinos still have the highest mental health need.
    - The concept of *unmet need* is of critical importance in assessing whether or not people with mental health needs are accessing and receiving adequate mental health services.

  - Minimally Adequate Treatment (MAT) is based on evidence-based guidelines for the treatment of a serious mental illness (SMI).
  - Improving mental health in California's increasingly diverse population will require diverse approaches and serious consideration of factors such as language, culture, stigma and discrimination, health insurance coverage, housing/neighborhood, etc.
  - MHSA and healthcare reform provide new opportunities to address and improve mental health services and outcomes, and to do so more efficiently.
  - Data and evidence (CHIS, DMH and Medi-Cal administrative data, County data, etc.) can and should be part of the decision-making process.
- Recommendations are as follows:
  - Obtain an accurate "baseline" assessment of mental health services need and treatment utilization in California. This will entail incorporating a follow-up study to validate the estimates of SMI/SPD and calibrate the cut point of the K6 in a statewide population.
  - Increase the CHIS sample size for low-income persons by oversampling households with incomes below 200 percent of the federal poverty level.
  - Increase CHIS sample size for key subpopulations such as diverse race/ethnicity/nativity, the institutionalized, the homeless, etc.
- California policy makers, decision makers, consumers and their families, providers, and researchers need to know:
  - Who needs (prevalence) and receives (current users) services?
  - How much of this need is met and how much need is unmet?
  - What are the gaps and needed changes in the health system?
  - What should the service population look like?

Questions

Vice Chair Van Horn wanted to know how households that use only cell phones and have no land lines will be accounted for when CHIS does future surveys. Dr. Aguilar-Gaxiola replied that random selections of phone numbers are done by area code and include cell phones.

Commissioner Carrion asked if there had been consideration given for people with some psychological distress, but not serious psychological distress as some of them may be functionally impaired. Dr. Aguilar-Gaxiola replied that there is a good understanding as to whether there is a level of impairment that does not meet the level of mental health need as well as a level of impairment related to other health conditions. There are some who do not cross the threshold of SPD on the K6 scale, and yet they have a moderate to severe impairment in their daily life. It would be interesting to see if there are different levels of impairment with SPD versus those with diabetes or hypertension. When comparing the top ten causes of disability, the number one condition is major depression. People who suffer from major depression tend to be more impaired than those with terminal cancer or those who are paraplegics. Out of the top ten health conditions causing disability, mental conditions produce the most disability; five out of ten are caused by mental disorders.

Commissioner Pating asked how sensitive the SPD data would be in terms of showing the impact of MHSA. Dr. Aguilar-Gaxiola responded that the estimates that had been studied in terms of sensitivity and specificity for the K6 had been very good.

Commissioner Nelson commented that the questions in the study were skewed toward depression rather than other mental illnesses. Dr. Aguilar-Gaxiola agreed, and explained that the K6 questions were found to be the best predictors of the various mental disorders.

Commissioner Nelson inquired whether room and boards were included in the study. Dr. Aguilar-Gaxiola replied that people in clinics or nursing care were not included because these are considered institutions. The study addressed the non-institutionalized household population of California.

Commissioner Poat asked about economic status versus cultural status. Dr. Aguilar-Gaxiola responded that even when there are controls for age, gender, income, and education, the study still found that, for example, U.S.-born Latinos have a significantly higher level of need.

Dr. Aguilar-Gaxiola thanked the MHSOAC staff for their partnership and the feedback that staff had given.

7. <u>Client and Family Leadership Committee</u>

Commissioner Nelson, the Client and Family Leadership Committee Vice Chair, stated that the Working Well Together (WWT) program is a collaboration of three client/family/patient care agencies and one mental health training and technical assistance organization:

- California Institute for Mental Health (CiMH)
- National Alliance on Mental Illness (NAMI) California
- United Advocates for Children and Families (UACF)

- California Network of Mental Health Clients (CNMHC)

Commissioner Nelson introduced the three representatives who were present to report to the Commission about the WWT program:

- Mr. John Aguirre, NAMI California WWT Technical Assistance Center (TAC) Coordinator, Central Valley Region
- Ms. Deborah Van Dunk, TAC Coordinator for WWT, Bay Area Region, UACF
- Ms. Michele Curran, CNMHC

Mr. Aguirre began by stating that WWT separated the State into five regions, and each of the partner agencies oversees one of those regions.

Ms. Curran named WWT's primary deliverables for 2008-2011:

- Providing technical assistance for individual counties
- Giving statewide training programs
- Supporting the website
- Providing workforce development tools
- Working in partnerships with the counties, states, and other academic and service provider groups
- Doing presentations about WWT for various groups

Ms. Van Dunk listed the tools and resources developed by WWT, including the WWT Consumer & Family Member Employment Development Assessment Tool and the WWT Recruitment and Retention Guidelines.

Ms. Curran stated that there have been numerous regional trainings presented throughout the State, all designed with the needs of the workforce in mind. Training has included job accommodations (how to employ people with life experience), developing effective job descriptions, and tackling employment barriers such as criminal record expungement.

Mr. Aguirre noted that one of the primary tools WWT uses to provide assistance to the counties is technical assistance on the ground. Coordinators develop relationships with the DMH in their regions. They work closely with MHSA coordinators as well as consumer/family members. Mr. Aguirre provided examples of technical assistance in various counties.

Ms. Van Dunk listed continuing and new deliverables for this year, including infrastructure development, product marketing/dissemination, and a toolkit on consumer/family member employment.

Ms. Van Dunk described a particular challenge encountered by WTT which was to create a welcoming environment for consumer/family member employees and to get existing staff to value those with lived experience.

She described the particular success of several consumers and family members being promoted to administrative positions.

Questions and Comments

Commissioner Wooton expressed appreciation for the work WTT is accomplishing, particularly dealing with employment barriers for consumer and family members in the mental health system and the stigma and discrimination that still surrounds it.

Ms. Curran noted that the role of trauma and subsequent healing should be considered going forward in preparing the workforce.

Commissioner Pating encouraged the WWT to think larger than just public sector. As we move into healthcare reform, the need for peer workforce should be applied to private and non-county systems as well. WWT's certificate program could be key in moving to a larger integration of peer workforce throughout the system.

Commissioner Poat suggested providing more numerical data to the MHSOAC, so that it can share with others the successes of MHSA-funded programs. Mr. Aguirre affirmed that this year WTT is developing more qualitative and quantitative data.

Public Comment

- Ms. Delphine Brody, CNMHC, commented on the CHIS survey presentation. Regarding met and unmet needs and minimally adequate treatment, she hoped that community-defined practices could be included among the approaches that are considered alongside job training, housing, and parenting and childcare resources, in looking at whether needs are being met. Peer support and culturally traditional healing modalities should always be included when looking at community-defined practices.
- Ms. Kathleen Derby, NAMI California, commented on the WWT program. She stressed the importance for a person with mental health needs to be surrounded by people with lived experience, who can not only comfort but also lead by example. Many of us also take for granted the willingness of those with lived experience to give back to their communities. This in itself is a huge part of overcoming the tremendous hurdle of stigma and discrimination.
- Mr. Perry Two Feathers Tripp, California Native American, CNMHC, stated that as an ambassador to the Inter-Tribal Council of California, it is very important for this Commission to recognize that there are governmental relationships with federally-recognized tribes throughout the State of California. He felt that the productivity of programs in our communities is not being fully utilized or accessed. The Commission must bear in mind cultural competence and relevance of evidence-based programs in our communities.

- Ms. Joy Torres said that she has been working on cultural competence in Orange County. The Vietnamese, the Spanish speakers, and the hard-of-hearing are not being adequately trained for positions, or trained at all for positions they may desire. She explained that field workers need to be remembered as a part of their culture, but that working on a farm is not necessarily a dream job. When people are not happy at work it disrupts the workplace. She expressed a need to be not only culturally competent, but diverse. There is a communication gap. Those who are mentally ill are not necessarily mentally incapable of working.

8. <u>General Public Comment</u>

- Mr. Clark offered a conclusion from a consumer perspective. Poverty is a predictor for mental health needs relative to the economic status of racial/ethnic minorities and the culturally majority poor. Accordingly, anti-poverty initiatives must be integrated with traditional mental health services.

  Regarding the WWT panel presentation, Mr. Clark asked if any official ties been made with the Department of Labor's Office of Employment for Disabled People and if there has ever been an evaluation of the Clinton Administration's Ticket to Work Act.

- Ms. Catherine Bond, client representative for the Los Angeles County Client Coalition and CNMHC, noticed a disconnect between the focus of the CHIS research and the following presentation on WWT. There needs to be further work done for the integration not just of best practices, but also promising practices and community-based practices for people who are looking for help, in the development of policies and procedures.

- Mr. Paul Aguilar, the Los Angeles Network, asked whether there were any plans for CHIS to do a survey of mental health for children and youth. Commissioner Van Horn responded that CHIS is a 50,000 person study done out of University of California, Los Angeles (UCLA) that only deals with adults. The California Youth Empowerment Network (CAYEN) is attempting to build a leadership cadre statewide. Commissioner Poat added that the MHSOAC is striving to design a framework that evaluates the population along age segments.

- Ms. Viviana Criado applauded the MHSOAC's decision to bring its role and responsibility in line with AB 100. She made three comments regarding the proposed Logic Model:

  1. The mission of the MHSOAC has been missed and should be up front.
  2. The values and principles of MHSA are buried and should be highlighted.
  3. The central role that consumers and families are to play in driving the system has not been stated.

- Ms. Stacie Hiramoto, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), commented on the CalMHSA report. CalMHSA was to be commended for working with REMHDCO to obtain the voice of consumer/family members and underserved representatives. Members of NAMI, REMHDCO, and UACF need to be commended for working very hard. Also, CalMHSA is not allowed to have consumer/family members on their Board, so they need to ensure the representation of consumer/family members and underserved communities in other ways.

9. Closed Session – Government Code Section 11126(a)

Chair Poaster stated that the Commission held a Closed Session in accordance with the Bagley-Keene Act, related to personnel issues. No reportable actions were taken.

10. Commission Discussion

How has the Commission's role changed as a result of AB 100 and recent state budget actions?

What are the critical functions to maintain in a changing mental health services environment? (Proposed *MHSOAC Principles* Document)

Chair Poaster set the stage for this item by noting that at the last full Commission meeting in May 2011, they had heard that the May Revise had upped the stakes regarding how statewide behavioral health services were going to be organized in the State of California.

Chair Poaster commenced a presentation on the Commission's role and critical state functions. He gave a background of the changes, including the realignment, AB 100, the proposed elimination of DMH and ADP, and the end of MHSOAC's requirement to review and approve county plans.

Chair Poaster quoted from the AB 100 mandate:

> "In eliminating state approval of county mental health programs, the Legislature expects the State, in consultation with the MHSOAC, to establish a more effective means of ensuring that county performance complies with the MHSA."

That is the real clarion call for the Commission – the real task in association with whatever state entity is in place.

Documents to assist in framing the discussion are *MHSOAC Principles to Support Reorganized Mental Health Administration* and *MHSOAC Logic Model*.

Chair Poaster and Vice Chair Van Horn find themselves being asked the question when talking with legislative staff, agency staff, and high Administration officials, "What does the Commission think?" To adequately answer this question the will or thought of the Commission on broad issues must be defined.

Executive Director Gauger spoke about the two documents and provided further background to the changes in the mental health system.

The Governor signed legislation that shifts the governance of the community mental health programs from the State to the counties. The Governor's May Revise proposed eliminating DMH and ADP in FY 2012/13. The Act established the Commission to oversee the MHSA and the Mental Health Systems of Care. The Act authorizes the Commission to advise the Governor or the Legislature regarding actions the State may take to improve care and services for those with mental illnesses. The Commission's established principles should inform decisions that will be made during the administration's reorganization of the mental health system.

- *MHSOAC Principles to Support Reorganized Mental Health Administration* highlights critical functions that MHSOAC staff has proposed to be maintained in the changing mental health system environment. The principles are grounded in statute.

  The seven proposed principles can be used to provide a basis for future discussion about the relationship between reorganized public mental health services and administration, and the Commission's responsibilities for oversight and accountability. These principles are:

  1. The State must continue to collect county data to support ongoing evaluation of California's mental health system.
  2. The State must continue to provide fiscal oversight for the expenditure of mental health services funds to ensure that funds are being spent consistent with the Act.
  3. The State must continue to pursue and support efforts to reduce or eliminate stigma and discrimination related to mental illness.
  4. The State must ensure that the perspectives of people with serious mental illness and their family members are considered in MHSA decisions and recommendations.
  5. The State must continue to support efforts to reduce and eliminate disparities, and access to, quality of, and outcomes of the mental health services.
  6. The State must ensure that counties are provided appropriate support including training in technical assistance, when appropriate, to achieve the outcomes that the Act specifies.
  7. Reorganization of State government and realigning services to counties offers an opportunity to transform the mental health system by integrating services.

- *MHSOAC Logic Model* tracks performance outcomes, particularly long-term social outcomes. Its components are:
    - Relevant statutes and policies
    - Possible oversight and accountability focus areas
    - Possible oversight and accountability strategies and actions
    - MHSOAC oversight and accountability outcomes
    - Mental health system outcomes

The Logic Model will allow the Commission to:

- Assist Commissioners in identifying the universe of possible oversight areas
- Clarify to the public and mental health stakeholders ways that the Commission oversees the public mental health system and ensures accountability
- Determine MHSOAC 2011 Workplan strategies
- Assess the Commission's success in areas of oversight and accountability, sound fiscal oversight, and effective evaluations

Discussion

Vice Chair Van Horn noted he and Executive Director Gauger will be expected to participate in meetings and talks with California Health and Human Services Agency and DMH over the next six weeks. They need to know the responsibilities of the MHSOAC by October 1, 2011.

Commissioner Pating asked if the issues of prevention and recovery/wellness fit into any category of the seven principles. All Commissioners present agreed that they should be included.

Commissioner Poat noted that important legislative decisions will be made and structured in the next several months, culminating in the budget proposal in January, 2012. The Commission's participation is crucial. He went on to say that he felt proposed Principle #7 was actually the organizing principle of the document.

Commissioner Wooton suggested adding language to the Principles document about the hiring of peers into the Mental Health system. She also suggested that clients and family members be involved in Training and Technical Assistance.

Commissioner Brown echoed some of Commissioner Poat's comments. He felt it is very important that this document be concise and not over laden with specificity. The Governor, Legislature, and public should be able to look at it and understand it, so it should not be too long.

He also agreed that proposed Principle #7 should be moved to the #1 position in the document.

Commissioner Nelson noticed that everything is validated by MHSA sections, yet the Commission still oversees all care and support systems. Is this included, or will it be addressed at a later time? Executive Director Gauger noted that the MHSA Section 10 points out the entire mental health system responsibilities.

Commissioner Pating commented that he would like to give authority to Chair Poaster, Vice Chair Van Horn, and Executive Director Gauger to speak to:

- Anything that would affect the transformation of the mental health system.
- Anything that would affect the MHSOAC rollout of the MHSA, including furthering the five principles of the Act.
- Anything that would affect this new Logic Model structure.

A clear sense of the MHSOAC's mission needs to be explained.

Commissioner Poat suggested that findings be added to the MHSOAC Principles to Support Reorganized Mental Health Administration document.

Commissioner Carrion questioned the term "finding." Commissioner Poat agreed that various styles could be used to write the document, and gave examples of what this broader term would cover.

Public Comment

- Ms. Torres agreed with the change of the term "should" to "must." She asked if the Commission was really looking into the training that is going on.
- Ms. Derby referred to the letter NAMI California had submitted in response to the proposed principles. They were concerned that the documents had not gone through any regular MHSOAC committees as they are important policies and warrant a wider perspective of public opinion. Yet NAMI California appreciated that the MHSOAC is examining its role, bringing forth this helpful tool to begin to examine the necessity of oversight.
- Ms. Bond read from a letter sent by the L.A. County Client Coalition to both the DMH and the California Health and Human Services Agency. Her organization is supporting the development of a separate department combining mental health services with alcohol and drug services. She expressed concern that the principles paper omitted anything referring to recovery and is concerned with the direction of the MHSOAC. She does not feel well represented and believes the committees should have presented the public with more information.

- Ms. Carolyn Caton, California Department of Social Services (CDSS), agreed with Ms. Derby that this is a very important discussion. CDSS is looking for opportunities to fit into the existing hierarchy and administration of mental health on a statewide basis. As MHSOAC has these discussions and forms a framework, Ms. Caton encouraged the Commission to look to other state agencies and potential partners – with their expertise and existing systems – for help in implementing oversight.

  As President of NAMI Sacramento, Ms. Caton commented that several of the principles are actually action steps, and if MHSOAC bases a framework on an action step and calls it a principle, it will have a very difficult time achieving its goals.

- Ms. Hiramoto presented a letter from REMHDCO. In no way does REMHDCO want to prevent the Commission from being involved in the reorganization talks; however, it seemed odd that MHSOAC could not negotiate using the principles and priorities of the Act – that it would need this document to move forward. In addition, obtaining meaningful input from REMHDCO on these documents would take more than the week that they were given.

- Ms. Brody, of CNMHC, commented that CNMHC strongly supports the letters of both NAMI California and REMHDCO on the Logic Model and the Principles. CNMHC could have benefitted from having a one month turnaround time to vet them with members. They hastily convened a meeting of their MHSA Client Implementation Team during which they came up with some comments, which Ms. Brody presented.

- Ms. Brazil Berkeley, former foster youth, agreed with Ms. Brody. As a former foster youth, with AB 100 now in effect and the transition of responsibilities of mental health funds landing in the counties (and with AB 3632 in the schools), she expressed concern with how youth will be taken care of. Counties have struggled to help youth with mental health services, period. When you add schools into the situation that makes it harder. She inquired how the MHSOAC will continue to meet the needs of the youth in the changing mental health environment.

- Mr. Frank Topping, private citizen and delegate of CNMHC, emphatically agreed with the statements made by NAMI California, REMHDCO, and CNMHC. He read from a draft proposal composed by the Sacramento County Mental Health Board Budget Committee to County of Sacramento, Assemblyman Roger Dickinson, and Senator Darrel Steinberg. It expressed dismay at the lack of information on mental health reorganization available, blocking many from participating in workshops and stakeholder meetings.

- Ms. Carmen Diaz, former MHSOAC Commissioner, commented that the Commission is making many decisions and recommendations while it is not fully represented by all required groups (i.e., family member). Also, nowhere in the presented documents are children or Transitional Age Youth (TAY) mentioned.
- Ms. Amber Burkan, CAYEN, commented that there is general anxiety around the loss of MHSA principles from consumer and family members. TAY have an additional anxiety around the loss of services for TAY as a specific age group. Her two requests were to keep the priority of TAY as a distinct age group with its own needs and services and that the language and lens across the lifespan be incorporated into all documents the MHSOAC is producing.
- Mr. Steve Leoni, consumer advocate, thanked Commissioners Pating, Poat and Brown for talking about Principle #7 and for moving it to the front. He further felt it needed to be enhanced with a wellness and recovery focus to be connected with the transformation of the system. He emphasized that the transformation is nothing less than the transformation of the way clinical work is conducted across the board.

  He also commented that Principle #3 should be supporting *all kinds* of employment, including within the mental health system.

Commissioner Pating and Executive Director Gauger acknowledged the executive team, Dr. Deborah Lee, and Mr. Thomas Powers for their fine work on the Logic Model.

Commissioner Poat suggested for the MHSOAC to establish two findings:

1. The State should champion a California-wide system that:
   - Reduces and eliminates stigma and discrimination.
   - Strengthens mental wellness.
   - Provides early screening and intervention of mental illness.
   - Funds universal access to recovery-based services and culturally sensitive settings.
   - Evaluates programs for recovery model outcomes.
2. The reorganization of State government in realigning services to counties offers an opportunity to transform the mental health system by integrating systems.

Commissioner Poat suggested that if the Commission passes the two findings then Chair Poaster, Vice Chair Van Horn, and Executive Director Gauger be granted authority to submit anything that advances the five objectives within the context of reorganization.

Commissioner Brown suggested flipping the two findings, and adding the words “and improve” to proposed Principle #7.

Motion: *Upon motion by Commissioner Poat, seconded by Commissioner Wooton, the Commission voted unanimously to adopt the MHSOAC Principles to Support Reorganized Mental Health Administration draft and Logic Model dated June 20, 2011 as amended with the findings noted above, with authority to the Executive Director to amend language consistent with the discussion heard today.*

11. Evaluation Committee

Presentation – "Draft Report for Public Input: 1) Standardized Template for Reporting CSS Priority Indicators, and 2) Process for Compiling Data to Produce Reports on CSS Priority Indicators"

Evaluation Committee Chair Van Horn introduced Dr. Elizabeth Harris of Evaluation, Management and Training Associates (EMT). Below is a summary of the presentation given by Dr. Harris.

- This particular deliverable charges the MHSA evaluation team with developing templates and reports using statewide and county-specific data that improves the understanding of how the MHSA has impacted consumers.
- The interim objective is to review the initial CSS priority indicators developed for Full Service Partnerships (FSPs) and the public mental health system by the Planning Council and approved by the MHSOAC.
- Goals were to define how CSS priority indicators were going to be measured, and how to make use of existing data sources.
- EMT examined where gaps existed, and proposed how to measure indicators where there were no existing measures for documentation. Possible additional data sources were also proposed.
- Dr. Harris supplied questions about indicators and data, to guide the feedback process for Draft Deliverables 2A and 2C.
- Feedback is requested on the draft deliverables up until the end of August 2011, so EMT can meet its deadline of September 30, 2011 for final products.
- Reports will reflect statewide and county-specific data that will improve understanding of how the MHSA has impacted consumers. Reports will come out in June, September, and December 2012.
- Individual client outcomes for FSPs by age group must be addressed for each domain. EMT has also provided options to assess for all individuals involved in the public mental health system, such as education, employment, and living situation.
- Mental health system performance must address six domains regarding perception of well-being, FSP demographics and access to primary care,

entire public mental health system factors, and community services and supports.

- At each step in the process, the priority indicator should be yielding useful information about how the MHSA is doing from start to finish.
- Criteria for measures to include for priority indicators were given.
- Criteria were considered as they related to practicality and quality.
- Websites with e-versions of the draft deliverables were given.

Public Comment

- Ms. Torres, CNMHC, commented that instead of wrapping around the whole family and connecting them, the TAY programs have lost sight of how invaluable it is to receive assistance when filling out applications. She inquired about the participatory process of evaluation, asking if stakeholders were getting information through the regions or if it was centralized.

  Dr. Harris informed Ms. Torres that the participatory process is now in the early phases and still in development.

Commissioner Poat questioned if an indicator required information that is not currently collected for some reason, would it prevent that measure from being used.

Dr. Harris replied that the Commissioners would have to weigh whether the existing measures give us what we want and is it worth the potential burden on counties to collect new measures.

12. <u>Panel Update on CalHFA</u>

Ms. Claudia Cappio, Executive Director of California Housing Finance Agency (CalHFA), and Ms. Jane Laciste, Chief of MHSA Plan Reviews & Community Program Support Section, DMH, gave a presentation titled "Mental Health Service Act Housing Program." Following is a summary.

- CalHFA is special program using MHSA funds for both capital costs and operating subsidies for the development of permanent supportive housing, which is housing that comes with wraparound services to support the client's recovery. There is no time limit on length of stay.
- The program is a unique partnership between DMH, CalHFA, and county mental health departments.
- The program was launched in August 2007. Of the $400 million made available from MHSA, $133 million was designated for operating subsidies. This is not enough for every single unit developed.
- Each county receives its own percentage of the program dollars and can plan development accordingly.

- With the recent real estate and credit market debacles, there are many properties available at lower land values; however, there is increased demand for rental properties and affordable housing.
- The MHSA Housing Program has enabled us to foster collaborative relationships and its financing is pivotal to some projects.
- The MHSA Housing Program has worked effectively with cities and counties throughout the State to make sure that MHSA is given priority and approvals.
- Economic challenges are unprecedented and resources and local funds are shrinking.
- The point of this program is to leverage other dollars and funding sources to build affordable housing. Over $1.7 billion has been leveraged with only $247.7 million in MHSA Housing Program funds.
- Program successes were listed regarding rental housing, shared housing, and age group housing.
- 21 developments are completed and are housing 220 MHSA eligible tenants. Large and small counties have submitted applications.
- The MHSA Housing Program is well ahead of schedule to meet the 2013 goal to produce the Capital projection of 2,530 units. It has financed 1,648 units to date.
- Figures for a financial update were given.
- Issues usually resolved were listed.
- Photographs of recently completed or renovated housing were shown.
- The program has proven to be a success.

Commissioner Poat asked how the recent changes in redevelopment law are affecting the program. Ms. Cappio responded that the end of redevelopment as we have known it for the last 30 years has the immediate consequence that up front there's much less "soft" money for project planning and approval. Mr. Bob Deaner of CalHFA asserted that projects already committed are secure.

Commissioner Pating thanked Ms. Laciste for her many years of leadership and work on the plan reviews and housing projects as she has been instrumental in their success. He asked if there is a way to continue this project by using administrative savings from the closure of DMH as a funding source.

Chair Poat replied that a significant amount of the money that's been leveraged in the past is now going to be used for education. Each region will now have to come up with its own funding sources for affordable housing.

Commissioner Nelson asked to whom the leveraging has gone – to those with or without mental illness? Ms. Laciste explained that the leveraged dollars are to develop a total of 5,900 units of affordable housing. They are for low income individuals who may have a variety of special needs or disabilities, including mental health. The MHSA units are specific to this program and target population. So far $247 million has been used of MHSA dollars for this target population.

Commissioner Pating asked if this project would be difficult to rekindle if the project funding was fully expended and no new funding sources were found. Is the infrastructure there? Ms. Laciste responded that the counties could choose to assign additional dollars out of their CSS allocations.

Mr. Deaner added that at CalHFA the option is still there. A good portion of the staff is trained to underwrite these real estate loans and if more dollars became available in the future, CalHFA could restart the program at any time. Ms. Laciste noted that at DMH a handful of individuals are remaining to continue running this program.

Chair Poaster remarked that this is an MHSA success story that needs to be told. The public needs to be informed about it in some way.

13. <u>General Public Comment</u>

- Mr. Topping shared his positive experience with the Turning Points Homeless Intervention Program. He has benefitted from AB 34.
- Ms. Eva Nuñez, Transitional Living and Community Support of Sacramento, supported the people in care homes. With all this money, are the clients going to be moved from care homes to housing? She also asked about how psychiatrist contracts are designed and licensed, and how money is allotted to Sacramento County Mental Health Treatment Center.
- Ms. Jennifer Wheeler expressed concern with getting housing for her two children who have mental illness. She felt that parents should be able to access the funds on behalf of their children.
- Ms. Derby expressed interest in finding out how local clients and family members are being helped in their communities. She addressed a situation in Contra Costa County where they were running into trouble with their Board of Supervisors regarding stigma and discrimination. Specifically, a therapeutic farm project was being blocked. However, as a result of strong advocacy and partnership with all stakeholders, the Board of Supervisors had completely reversed their position and voted to support the project.

- Ms. Anne Cory, Corporation for Supportive Housing (CSH), Oakland office, commented that CSH has provided training and technical assistance for the MHSA housing program for the last four years. It is clear that technical assistance was extremely important in achieving the level of success of the MHSA Housing Program. This housing technical assistance program is one of the pieces that has fallen through the cracks in the transition under AB 100.

  Chair Poaster asked staff to make a note to get information on the relationship between this housing project and CSH.

14. <u>Adjournment</u>

Chair Poaster adjourned the meeting at 4:06 p.m.